FIRST THINGS FIRST

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January 14, 2010

Chairman Lynn and Members of the Board
First Things First
4000 North Central Avenue, Suite 800
Phoenix, AZ 85012

RE: Central Phoenix Regional Partnership Council Health Care Coordination Strategy

Dear Chairman Lynn and Members of the Board:

The Central Phoenix Regional Partnership Council is pleased to present an updated strategy, Health Care Coordination, for your review and approval. While planning for the FY2010 funding plan, the Council discussed methods to address children not receiving adequate preventative care in the Central Phoenix corridor. In the original funding plan, the Council proposed a health care strategy which developed into a health care coordination model for children and families. The Council's health workgroup determined that a health care coordination medical home model was the most effective way to address gaps in preventive care.

Program Model Overview:

The Regional Council plans to implement a program to provide health care access/coordination services, based on successful models in other states. The program will enable high-risk families to gain access to basic health services for their young children.

The model addresses the specific gaps to care as identified in the Central Phoenix corridor:

- Gaps in available health care for young children, including children already enrolled in health coverage;
- Challenges accessing needed health services for families with young children, especially children in crisis situations;
- Challenges accessing and maintaining health coverage for young children at-risk or in crisis situations.
- Challenges coordinating family support and health care services for children with complex needs.

The Council has allocated $1,000,000 to implement this strategy; and the Council plans to implement this strategy through an RFGA process. Potential applicants may include (but will not be limited to) hospitals, community health centers, physicians' associations or networks, and community-based organizations.

The Central Phoenix Council is pleased to offer this strategy update and is confident that the model will facilitate greater access to preventative care for families with

young children through a depth and scope of coordination not yet existing in the area.

Thank you for your consideration.

Respectfully,

Judi Gottschalk JKC

Judi Gottschalk, Chair
Central Phoenix Regional Partnership Council

Cc: Tracey K. Craig, Regional Coordinator (Interim)
Tracey K. Craig, Regional Manager

Appendix A
STRATEGY WORKSHEET

Strategy 10: Increase children's access to preventive health care through Care Coordination

According to the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, & American Osteopathic Association (2007), the key elements of the medical home are: a physician who has an ongoing relationship with patients and arranges care with other qualified professionals; the implementation of evidence-based medicine, quality improvement measures, information technology, and patient participation in care decisions; improved access to care that includes open scheduling, expanded hours, and new options for communication with patients; and a payment system that recognizes the medical expertise, administrative requirements, and time demands of providing a personal medical home.

A medical home is not a place. It is an approach and process to health care in the primary care setting. It emphasizes a partnership among the patient, physician, practice staff, and, if present, the primary care giver. The practice becomes the place (or home) where patients are known, recognized and supported; where they find a centralized base for medical care and connection to other medical and supportive community services. While this is the ideal, in a variety of circumstances it is difficult to make it happen.

The Central Phoenix Regional Partnership Council recognizes the importance and challenges of connecting children to the health care services they need. A child's good health is the foundation for a lifetime of opportunity and success. Unfortunately Arizona children often do not get connected to the health coverage, health care, and support services they require to maintain good health. For example, Arizona has the highest rate of uninsured children in the country who do not receive health care during the year, according to the Robert Wood Johnson Foundation.[1]

The Central Phoenix Regional Partnership Council has developed a myriad of health care strategies that will not only help connect families with young children to health coverage (Strategy 6), but will also support critical physical and mental health screenings (Strategies 3 and 7), and other family support services to promote better health for children 0 through 5 (Strategy 12, 13 & 24). In addition, the Central Phoenix Regional Council hopes to improve the quality of health care services by educating physicians and resident physicians about the importance of integrating a family-focused, developmental, and preventative care approach into the delivery of health care for young children (Strategy 8).

To fully address the health care needs of children in the region, the Central Phoenix Regional Council recognizes that we must go beyond simply enrolling more children in public health insurance programs and improving their access to health screenings. We must ensure that the existing health care services in this region are sufficient to meet the needs of families and measure up to the best practice standards of comprehensive health care for children 0 through 5. We also need to identify and remove the barriers that jeopardize continuity of care for young children and prevent some families from accessing health care services that are vital to their child's overall well-being.

There are a number of barriers that families in the region face in accessing health care and maintaining the continuity of care that young children require. Such barriers are most profound among families in crisis situations, such as those experiencing homelessness, domestic violence or with chronic health

care needs.

Families and care providers often face challenges accessing or coordinating needed care. Families in crisis (e.g. those in domestic violence situations) may not be able to get needed documentation to enroll their children in public health coverage. Those same families may also need multiple family support and health services. Referrals to such services are often quite haphazard, and families and service providers often struggle to figure out how to "piece together" a disconnected array of health resources. Families and service providers often need advice and assistance in obtaining available services, navigating complex systems and bureaucracies, and coordinating care.

To address these issues, and to accomplish First Things First's goal to collaborate with existing Arizona early childhood health care systems to improve children's access to quality health care (Goal #4) and to build on current efforts to increase the number of health care providers utilizing a medical and dental home model (Goal #5), the Central Phoenix Regional Council proposes the following:

> Implement care coordination and support for families in crisis situations – As described above, families with young children in crisis situations often have complicated needs. Piecing together health and family support services and enrolling and retaining children in health coverage are time consuming and difficult for families in crisis. The Central Phoenix Regional Council plans to implement a program to provide Health Care Access Coordination services, based on successful models in other states, to assist high-risk families in the region access basic health services for their young children. The goal would be to increase the number of children with health coverage by providing insurance enrollment assistance as well as follow-up "care coordination" assistance to families to ensure that each child utilizes their medical home and maintains their health coverage.

There are a number of successful national models which have demonstrated impressive health outcomes for children 0 through 5 by offering these high-risk families additional supports to access health care.

For example, in Orange County, California, a model has been developed and implemented aimed at linking children and their families to the appropriate care they need and coordinating complex service delivery to make sure the right care is provided. Health Care Access Coordinators act as child and family advocates, providing assistance in coordinating service delivery. These Coordinators refer providers and families to appropriate resources, help families and service providers navigate system barriers, and help families obtain health coverage. Studies show that 81 percent of the children 0 through 5 served by the program were assisted in securing a medical home, while another 8 percent had improved accessibility to a medical home by the time they left the program. The percentage of the children with full immunizations was also increased from 43 percent to more than 75 percent.

In order to weave a sometimes patchwork of health and social services into a coherent and comprehensive system of services, the Central Phoenix Regional Partnership Council will develop care coordination processes within a variety of potential settings, such as provider practices, hospitals and community based agencies. Effective care coordination enhances access to needed services and resources, promotes optimal health and functioning of children, and supports improved quality of life. Data shows that primary care physicians struggle to fulfill the care-coordination needs of children, youth, and families. Care is coordinated and/or integrated across all elements of the complex health care and social services systems (e.g., subspecialty care, hospitals, home health agencies, health plans)

and the patient's community (e.g., family, schools, childcare, public and private community-based services). Care coordinators will enhance the abilities of the physician and practice to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Responsibilities of the care coordinators may include, but are not limited to assisting in:

1. scheduling and following up on appointments
2. assessing patient (and families') needs
3. planning and ensuring implementation of care
4. assuring access to care (insurance or social services)
5. obtaining authorization of services
6. monitoring service provision
7. tracking referrals
8. brokering or obtaining resources
9. providing/linking families to support and education
10. providing service coordination with other community resources, to make an effort to minimizing duplication and to ensuring that families receive comprehensive services as needed.
11. providing reminder/recalls for preventive/diagnostic care
12. implementing technology including electronic health records and e-prescribing tools to support medical home processes
13. providing care coordination regardless of payor source

Care coordinators will NOT be responsible for performing medical procedures or treatments, giving medical advice, writing reports generally prepared by physicians or nurses and performing routine bookkeeping, clerical or billing functions.

It is also the desire of the Central Phoenix Regional Partnership that there will be collaborative working relationships between the care coordination sites, care coordinators, health practitioners in the region, Child Care Health Consultants, health plan EPSDT Coordinators and home visitation efforts located in the region to address:

- Gaps in available health care for young children, including children already enrolled in health coverage;
- Challenges accessing needed health services for families with young children, especially children in crisis situations;
- Challenges accessing and maintaining health coverage for young children at-risk or in crisis situations.
- Challenges coordinating family support and health care services for children with complex needs.

The Central Phoenix Regional Partnership Council has devoted $1,000,000 to implement this strategy. The Central Regional Partnership Council plans to implement this strategy through an RFGA process. Potential applicants may include (but will not be limited to) hospitals, community health centers, physicians' associations or networks, and community-based organizations.

Applicants to provide care coordination services will have to identify how they will identify available community services. Applicants will also need to describe how they will work with existing public

programs, navigating the complex array of eligibility requirements. Care coordinators will connect families to a broad array of social and family support services and public programs (AZEIP, ADE, AHCCCS, CRS, DDD, ALTCS, DES etc.) necessary to meet the needs of the young child, and promote the optimal development of the child.

Applicants will also be required to describe how they will work with physicians' practices to foster learning about available community resources, appropriate referrals, eligibility requirements of various public programs, and the benefits of care coordination. The goal of such a feedback loop is to ensure that care coordination is continued by practices after FTF funding is exhausted.

The Central Phoenix Regional Partnership Council would also require that an independent evaluation of the program would occur on a yearly basis.

Robert Wood Johnson Foundation, Covering Kids and Families. "The State of Kids Coverage," August 9, 2006.

Lead Goal 11: FTF will coordinate and integrate with existing education and information systems to expand families' access to high quality, diverse and relevant information and resources to support their child's optimal development.

Goal 4: FTF will collaborate with existing Arizona early childhood health care systems to improve children's access to quality health care.

Goal 5: FTF will build on current efforts to increase the number of health care providers utilizing a medical and dental home model.

Key Measures:

- Total number and percentage of children with health insurance
- Total number and percentage of children receiving appropriate and timely well-child visits
- Total number and percentage of health care providers utilizing a medical home model
- Ratio of children referred and found eligible for early intervention
- Total number and percentage of public and private partners who report that FTF planning process and activities use family centered practices (e.g. builds on family strengths, connects families with community resources, facilitates family interaction with early care and education professionals, offers the possibility of family and community input at all levels of decision-making)

Target Population

At risk Families with young children (0 through 5) in Central Phoenix

Proposed Service Numbers	SFY 2011 July 1, 2010 – June 30, 2011	SFY2012 July 1, 2011 - June 30, 2012	SFY2013 July 1, 2011 - June 30, 2012

	7 practices	7 practices	7 practices

Performance Measures SFYs 2011-2012

- Number and percentage of children with health insurance
- Number and percentage of children receiving appropriate and timely well-child visits
- Number and percentage of health care providers utilizing a medical home model
- Total number and percentage of public and private partners who report that FTF planning process and activities use family centered practices (e.g. builds on family strengths, connects families with community resources, facilitates family interaction with early care and education professionals, offers the possibility of family and community input at all levels of decision-making)

SFY2011Expenditure Plan for Proposed Strategy

Allocation for proposed strategy	$1,000,000

Budget Justification:

A: Cost for six full-time Medical Home Care Coordinators is estimated at $125,000 each (inclusive of salary, ERE, supplies, mileage reimbursement, outreach and administrative costs) for a total of $875,000. The administrative entity that will employ, possibly house and supervise the Medical Home Care Coordinators will be determined through a competitive RFGA process. Medical Home Care Coordinators could be housed within the administrative agency or within specific clinics or practices depending on the determination of how best to deliver their services. A realistic sustainability plan must be submitted with the grant proposal for these services. Examples of this may include a cost share by the Physician/Practice for the funding of the Care Coordinator in years two and three.

B: Cost of an Independent Evaluator - $125,000. The various activities to be covered in the evaluation include:

1) collection, storage, and analysis of individual medical records and data follow-up; and

2) outcome evaluation at the end of programming.